

My Kidz Dentist, P.C.

"Dentistry and Orthodontics for Children and Teenagers"

Welcome to our office

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out both pages completely. If you have any questions we'll be glad to help you.
Thank You.

TODAYS DATE: _____

CHILD'S LEGAL NAME _____ NICK NAME _____

D.O.B. _____ Male _____ Female _____

CHILD LIVES WITH: BOTH _____ FATHER _____ MOTHER _____ OTHER _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (480) (602) (623): _____ WK/CELL _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

MOTHER'S LEGAL NAME: _____ DOB _____ SS# _____

DRIVERS LICENSE # _____ STATE _____ EXPIRES _____

ADDRESS IF DIFFERENT THAN CHILD'S: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: (480) (602) (623) _____ SPOUSE NAME: _____

FATHER'S LEGAL NAME: _____ DOB _____ SS# _____

DRIVERS LICENSE # _____ STATE _____ EXPIRES _____

MARTIAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

ADDRESS IF DIFFERENT THAN CHILD'S: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: (480) (602) (623) _____ SPOUSE NAME: _____

NAME OF ADULT ACCOMPANYING CHILD TODAY? _____

RELATIONSHIP TO CHILD: _____ PHONE: _____

DENTAL INSURANCE CO/AHCCCS PLAN: _____

INSURED NAME: _____ INSURANCE/AHCCCS ID # _____

INSURANCE PHONE: () _____ GROUP# _____

NAME AND AGES OF BROTHERS AND SISTERS _____

FAMILY DENTIST: _____ PHONE: () _____

WHO REFERRED YOU TO US? _____ PHONE: () _____

OTHER THAN PARENT/GUARDIAN. WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?

1. NAME _____ RELATIONSHIP _____ PHONE _____

2. NAME _____ RELATIONSHIP _____ PHONE _____

CHILDS NAME _____ DOB _____

CHILDS PHYSICIAN: _____ PHONE: _____

IS YOUR CHILDS ALLERGIC TO, OR HAD ANY UNFAVORABLE REACTIONS TO DRUGS, INCLUDING ANTIBIOTICS AND LOCAL ANESTHETIC SOLUTIONS? ___Y ___N. IF YES, WHICH ONES AND WHAT FOR? _____
HAS YOUR CHILD EVER BEEN HOSPITALIZED? ___Y ___N. IF YES WHAT FOR? _____

MEDICAL HISTORY: DOES YOUR CHILD HAVE, OR HAS HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES OR NO			YES OR NO	
ALLERGIES	<input type="radio"/>	<input type="radio"/>	CEREBRAL PALSY	<input type="radio"/>	<input type="radio"/>
RHEUMATIC FEVER	<input type="radio"/>	<input type="radio"/>	LIVER DISORDER	<input type="radio"/>	<input type="radio"/>
BLEEDING DISORDER	<input type="radio"/>	<input type="radio"/>	PHYSICAL HANDICAP	<input type="radio"/>	<input type="radio"/>
SEIZURES	<input type="radio"/>	<input type="radio"/>	KIDNEY DISORDER	<input type="radio"/>	<input type="radio"/>
HEART PROBLEMS	<input type="radio"/>	<input type="radio"/>	DIABETES	<input type="radio"/>	<input type="radio"/>
HEPATITIS	<input type="radio"/>	<input type="radio"/>	LEARNING DISABILITIES	<input type="radio"/>	<input type="radio"/>
CANCER	<input type="radio"/>	<input type="radio"/>	HIV+/AIDS	<input type="radio"/>	<input type="radio"/>
BRAIN INJURY	<input type="radio"/>	<input type="radio"/>	ASTHMA	<input type="radio"/>	<input type="radio"/>
EPILEPSY	<input type="radio"/>	<input type="radio"/>	SPECIAL NEEDS	<input type="radio"/>	<input type="radio"/>
TUBERCULOSIS	<input type="radio"/>	<input type="radio"/>	ALLERGIC TO LATEX	<input type="radio"/>	<input type="radio"/>

HAS YOUR CHID EVER NEEDED ANTIBIOTICS BEFORE THEY HAND DENTAL TREATMENT? ___Y ___N. IF YES WHY WAS IT GIVEN? _____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT SURGERIES, SPECIAL NEEDS OR ANY MEDICAL INFORMATION WE SHOULD BE AWARE OF THAT HAS NOT YET BEEN DISCUSSED: _____

IS YOUR CHID TAKING ANY FORM OF FLUORIDE (TABLETS, DROP, MOUTH RINSES OR GELS)? ___Y ___N IF YES, WHICH ONES? _____

DOES YOUR CHID HAVE THUMB SUCKING, FINGER SUCKING, LIP SUCKING, NAIL BITING, NURSING BOTTLE OR PACIFIER HABITS? ___Y ___N IF YES, DESCRIBE _____

HAS YOUR CHILD HAD ANY UNFAVORABLE EXPERIENCE IN A DENTAL OFFICE? ___Y ___N IF YES, DESCRIBE _____

HAS YOUR CHILD RECEIVED ANY INJURIES TO THE MOUTH OR TEETH? ___Y ___N IF YES, WHEN? _____

HAS YOUR CHILD HAD A TOOTHACHE RECENTLY? ___Y ___N SPECIFY, AREA: _____

HAS YOUR CHILD BEEN TO THE DENTIST BEFORE? ___Y ___N IF YES, WHEN? _____

DO YOU HAVE ANYTHING YOU WISH TO DISCUSS WITH THE DOCTOR TODAY? _____

REVIEW BY/DOCTOR: _____ DATE _____

MEDICAL/DENTAL RELEASE STATEMENTS

I GIVE CONSENT FOR THE DOCTOR OF MKD TO COMPLETE A THOROUGH EXAMINATION ON THE PATIENT PREVIOUSLY NAMED, INCLUDING ANY NEEDED DIAGNOSTIC RADIOGRAPHS. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION THAT I HAVE PROVIDED IS CORRECT AND I UNDERSTAND THAT I WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IN ACCORDANCE TO ALL STATE AND FEDERAL HIPPA REGULATIONS. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MKD OF ANY CHANGES TO MY CHILD'S MEDICAL STATUS. _____ (INITIALS)

AUTHORIZATION FOR DIRECT PAYMENT

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO MY KIDZ DENTIST. FURTHERMORE, IN THE EVENT OF PAYMENT DEFAULT FOR SERVICES PREVIOUSLY RENDERED, I ALSO AGREE TO PAY ALL REASONABLE COLLECTION AND/OR LEGAL FEES INCURRED IN AN ATTEMPT TO COLLECT ON THIS EVENT. _____ (INITIALS)

RELEASE FOR FILING INSURANCE CLAIM & FINANCIAL RESPONSIBILITY STATEMENT

I AUTHORIZE THE RELEASE OF INFORMATION TO MY CHILD'S DENTAL INSURANCE COMPANY. I AM AWARE THAT MKD WILL BE PROVIDING AN ESTIMATE OF INSURANCE COVERAGE PRIOR TO INITIATING ANY FUTURE TREATMENT AND THAT I AM LEGALLY RESPONSIBLE FOR ANY PORTION NOT PAID BY THIS POLICY. FURTHERMORE, I AM AWARE OF MY FINANCIAL RESPONSIBILITY SHOULD MY INSURANCE POLICY FAIL TO PAY, FOR ANY REASON, WITHIN 30 DAYS OF RECEIVING SUCH TREATMENT. _____ (INITIALS)

SIGNATURE OF PARENT OR GUARDIAN: _____

DATE _____

PAYMENT IS DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

WILL YOU BE PAYING BY : CASH: _____ CHECK: _____ CREDIT CARD: _____